House of Representatives

General Assembly

File No. 174

January Session, 2001

Substitute House Bill No. 6796

House of Representatives, April 9, 2001

The Committee on Human Services reported through REP. GERRATANA of the 23rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-427 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) The "CHOICES health insurance assistance program" means the federally recognized state health insurance assistance program funded pursuant to P.L. 101-508 and administered by the Department of Social Services, in conjunction with the area agencies on aging and the Center for Medicare Advocacy, that provides free information and assistance related to health insurance issues and concerns of older persons and other Medicare beneficiaries in Connecticut; and

(2) "CHOICES" means Connecticut's programs for health insurance assistance outreach information and referral, counseling and eligibility

screening.

[(a)**]** (b) The Department of Social Services shall **[**establish a program to provide assistance to Medicare**]** administer the CHOICES health insurance assistance program, which shall be a comprehensive Medicare advocacy program that provides assistance to Connecticut residents who are Medicare beneficiaries. The program shall: (1) **[**Provide for**]** Maintain a toll-free telephone number to provide advice and information on Medicare benefits, **[**and**]** the Medicare appeals process **[**from**]** and other health insurance matters applicable to Medicare beneficiaries at least five days per week during normal business hours; (2) provide information, advice and representation, where appropriate, concerning the Medicare appeals process, by a qualified attorney or paralegal at least five days per week during normal business hours; **[**and (2) provide for the preparation and distribution of**]** (3) prepare and distribute written materials to Medicare **[**patients**]** beneficiaries, their families, **[**and**]** senior **[**citizen**]** citizens and organizations regarding Medicare benefits; (4) develop and distribute a Connecticut Medicare consumers guide, after consultation with the Insurance Commissioner and other organizations involved in servicing, representing or advocating for Medicare beneficiaries, which shall be available to any individual, upon request, and shall include: (A) Information permitting beneficiaries to compare their options for delivery of Medicare services; (B) information concerning the Medicare plans available to beneficiaries, including the traditional Medicare fee-for-service plan and the benefits and services available through each plan; (C) information concerning the procedure to appeal a denial of care and the procedure to request an expedited appeal of a denial of care; (D) information concerning private insurance policies and federal and state-funded programs that are available to supplement Medicare coverage for beneficiaries; (E) a worksheet for beneficiaries to use to evaluate the various plans; and (F) any other information the program deems relevant to beneficiaries; and (5) include any functions the department deems necessary to

conform to federal grant requirements.

(c) The Insurance Commissioner, in cooperation with, or on behalf of, the Commissioner of Social Services, may require each Medicare organization to: (1) Annually submit to the commissioner any data, reports or information relevant to plan beneficiaries; and (2) at any other times at which changes occur, submit information to the commissioner concerning current benefits, services or costs to beneficiaries. Such information may include information required under section 38a-478c.

(d) Each Medicare organization that fails to file the annual data, reports or information requested pursuant to subsection (c) of this section shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each Medicare organization that files incomplete annual data, reports or information shall be so informed by the Insurance Commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(e) Not later than June 1, 2001, and annually thereafter, the Insurance Commissioner, in conjunction with the Managed Care Ombudsman, shall submit to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and insurance and to the select committee of the General Assembly having cognizance of matters relating to aging, a list of those Medicare organizations that have failed to file any data, reports or information requested pursuant to subsection (c) of this section.

[(b)**]** (f) All hospitals, as defined in section 19a-490, which treat persons covered by Medicare Part A shall: (1) Notify incoming patients covered by Medicare of the availability of the services established pursuant to subsection **[**(a)**]** (b) of this section, (2) post or cause to be

posted in a conspicuous place therein the toll-free number established pursuant to subsection **[**(a)**]** (b) of this section, and (3) provide each Medicare patient with the toll-free number and **[**directives on**]** information on how to access **[**to**]** the CHOICES program.

Sec. 2. Section 17b-427a of the general statutes is repealed.

Sec. 3. This act shall take effect from its passage.

HS *JOINT FAVORABLE SUBST.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Workload Increase, Potential Minimal Revenue Gain

Affected Agencies: Departments of Insurance and Social Services

Municipal Impact: None

Explanation

State Impact:

The CHOICES program is a federally funded, comprehensive Medicare advocacy program that provides assistance to state Medicare beneficiaries. The Department of Social (DSS) administers the program. This bill clarifies existing statutes to match the current scope of the CHOICES program. As such, no fiscal impact to DSS is anticipated.

The bill also allows the Department of Insurance (DOI) to require managed care organizations (MCO's) to annually submit certain information concerning Medicare plans. Any such organizations that fail to submit the required information are subject to a $100 per day fine for each day that the information is not received. DOI must annually submit to the General Assembly a list of those MCO's that have not furnished the required information.

DOI will incur a workload increase related to the compilation and submission of the list of non-compliant MCO's. It is expected that this increase can be absorbed within DOI's normal budgeted resources.

There is also a potential revenue gain from the collection of late fees from the MCO's. Any such gain is expected to be minimal.

OLR Bill Analysis
sHB 6796

AN ACT CONCERNING THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM.

SUMMARY:
This bill consolidates statutory provisions on the existing CHOICES health insurance assistance program and the Connecticut Medicare consumers guide and updates them to reflect current practice and the cooperative roles of the Center for Medicare Advocacy and the area agencies on aging. It (1) specifies that the program must be a comprehensive Medicare advocacy program that not only provides information and advice for Medicare beneficiaries, but also legal representation where appropriate; (2) specifically allows non-attorneys to give advice on Medicare benefits on the program's toll-free phone number; (3) eliminates the only statutory definitions of "Medicare organization" and "Medicare plan"; (4) specifies that the program must include any functions the Department of Social Services (DSS) deems necessary to conform to federal grant requirements; and (5) makes several minor and technical changes.

The bill also codifies and defines the CHOICES program, of which the health insurance assistance program is one part.

Currently, the insurance commissioner, who cooperates in collecting data for the guide, must annually give the governor and three specified legislative committees a list of Medicare organizations that have not filed timely data with him. The bill changes one of the legislative committees that receive this report from the Public Health Committee to the Human Services Committee. The bill requires that, by June 1, 2001, the commissioner must submit this list in conjunction with the managed care ombudsman (a position created in 1999 and in the Insurance Department for administrative purposes only).

EFFECTIVE DATE: Upon passage

BACKGROUND

CHOICES

The "CHOICES health insurance assistance program" is a federally recognized and mainly federally funded program, run by DSS in cooperation with the Area Agencies on Aging and the nonprofit Center for Medicare Advocacy. The program offers senior citizens health insurance information and counseling, as well as information on Medicare and Medicare managed care plans. It is part of a collection of senior programs run by CHOICES, which is located within DSS' division of elderly services. The acronym stands for Connecticut's programs for Health insurance assistance, Outreach, Information and referral, Counseling, and Eligibility Screening.

Area Agencies on Aging

The five area agencies on aging in Connecticut are local, private nonprofit organizations that serve the needs of the elderly. They provide planning and financial support to other agencies serving the elderly. They help administer certain federal and state senior programs and provide other information and referral services.

Center for Medicare Advocacy

The Center for Medicare Advocacy is a nonprofit organization that offers Medicare-related legal advice, material, and representation to seniors and people with disabilities. It already is cooperating with CHOICES and provides legal representation in Medicare appeals where appropriate.

Medicare Consumer Guide

The CHOICES program has issued a comparison of Medicare HMOs for a number of years. 1999 legislation required the program, in cooperation with the insurance commissioner, to create a Medicare consumers guide with additional information so Medicare beneficiaries can compare the different Medicare plans and supplemental policies available and learn about Medicare appeals procedures. That law allows the insurance commissioner, in

cooperation with or on behalf of the social services commissioner, to require each Medicare organization to submit certain information to him to be included in the guide. It also imposes penalties on those that do not file the required information.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 14 Nay 0